

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04727

4727

## CERTIFICATE OF DEATH

Reg. Dist. No. 198

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> <u>Howard</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
X TOWN <u>Ellicott City</u>		STREET ADDRESS (If rural give location) <u>1034 E. North Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor Nurs. Ho.</u>			
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) (Middle) (Last) <u>MATTIE (MAGGIE) L. CRADDOCK</u>		<u>May 16 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Jan. 15, 1867</u>
9. AGE last birthday: <u>88</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Joseph N. Craddock</u>		14. MOTHER'S MAIDEN NAME: <u>Anna Hubbard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. Mattie Craddock-1034 E. North Ave.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>443X</u>			
ANTECEDENT CAUSE (5):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 16, 1955</u> , to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>M. from the causes and on the date stated above.</u>			
SIGNATURE <u>Robert B. Taylor</u>		DATE SIGNED <u>May 17, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THE OF <u>5/18/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-17-55</u>	REGISTRAR'S SIGNATURE <u>and Hedding</u>	FUNERAL DIRECTOR <u>Wm. J. Pickner</u>	ADDRESS <u>Sou. Balto 17 Ave</u>

THE NATIONAL ARCHIVES COLLEGE PARK, MARYLAND

OFFICE OF THE DIRECTOR

WASHINGTON, D.C. 20540

RE:

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Reg. Dist.

No. 193

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
<input checked="" type="checkbox"/> TOWN <u>Woodbine</u>				TOWN <u>Woodbine</u>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Annapolis Rock Road</u>				STREET ADDRESS (If rural, give location) <u>Annapolis Rock Road</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Mortimer</u>		(Middle) <u>Dorsey</u>		(Last) <u>Duvall</u>		(Month) <u>May</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH: <u>9/28/1883</u>	
9. AGE last birthday: <u>71</u> yrs.		10. AGE last birthday: <u>71</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Woodbine, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>			
13. FATHER'S NAME: <u>John Wesley Duvall</u>				14. MOTHER'S MAIDEN NAME: <u>Victoria Evelyn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>213-32-3510</u>		17. INFORMANT & ADDRESS: <u>Benj. F. Duvall, Eccleston, Balto. Co. Md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				<u>Instant</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
<u>Woodbine Howard Md</u>					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>George E. Buntorf</u>		Ellicott City, Md.		M. D. <u>May 14, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>5/17/1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Jennings Chapel</u>	
LOCATION (City, town, or county) (State): <u>Florence, Howard Co., Md.</u>		24. FUNERAL DIRECTOR: <u>F.C. Higinbotham</u>		ADDRESS: <u>Ellicott City, Md.</u>	

DATE RECD BY LOCAL REG. 5-3-1955 REGISTRAR'S SIGNATURE C. Pearl Murch

F.C. Higinbotham Ellicott City, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

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RECEIVED

04728

MARYLAND

STATE DEPARTMENT OF HEALTH

4728

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>	
TOWN <u>Cooksville</u>		TOWN <u>Cooksville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Sarah</u> (First) <u>Jane</u> (Middle) <u>Francis</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>19</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 25, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
11. FATHER'S NAME <u>George Berry</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Ella Dorsey</u>	
15. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Albert Francis - Cooksville, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>Feb 55</u> <u>May 55</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>434.2</u> Immediate cause (a) <u>Cardiac Arrest - Cardiac failure</u> Antecedent cause(s) (b) <u>arteriosclerosis, pulmonary disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>  </u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>  </u>	19b. MAJOR FINDINGS OF OPERATION <u>  </u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1955, to May, 1955, that I last saw the deceased alive on 19 May, 1955, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE Howard E Hall MD (Degree or title) ADDRESS Cooksville, Md DATE SIGNED 19 May 55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5-22-55</u>	NAME OF CEMETERY OR <u>Dorsey Family</u>	LOCATION (City, town, or county) <u>Cooksville, Howard Md</u>
DATE REC'D BY LOCAL REG. <u>May 21, 1955</u>	REGISTRAR'S SIGNATURE <u>E Paul M...</u>	24. FUNERAL DIRECTOR <u>Arthur H Haight</u>	ADDRESS <u>Cooksville, Md</u>

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MAY 31 1955

BUREAU V. S.



04729

MARYLAND

STATE DEPARTMENT OF HEALTH

4729

## CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>High Ridge, Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>High Ridge, Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Emma</u> (Middle) <u>Nelena</u> (Last) <u>Grimes</u>		(Month) <u>May</u> (Day) <u>2</u> (Year) <u>1955</u>	
6. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md</u>	9. AGE last birthday <u>57</u> yrs. If under 1 year Months Days Hours Min.
13. FATHER'S NAME <u>James Redmond</u>	14. MOTHER'S MAIDEN NAME <u>Ella Para Steader</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
<u>no</u>		<u>no</u>	
17. INFORMANT AND ADDRESS <u>Thomas C. Redmond Laurel Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
(a) <u>420.1 Acute Coronary Occlusion</u>			
(b) <u>Coronary Insufficiency</u>			
(c) <u>Acute Viral Infection</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>NONE</u>	19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE <u>NONE</u> (Specify)	PLACE (Home, farm, factory, street, OF office building, etc.) <u>NONE</u>	(CITY OR TOWN) <u>NONE</u>	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>NONE</u>	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not while at Work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>NONE</u>	

22. I hereby certify that I attended the deceased from 3/1, 1955, to 5/2, 1955, that I last saw the deceased alive on 4/26, 1955, and that death occurred at 2:05 P.m., from the causes and on the date stated above.

SIGNATURE J. M. Warren Md ADDRESS Laurel DATE SIGNED 5/2/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE May 4, 1955 NAME OF CEMETERY OR CREMATORY St. John Cemetery LOCATION (City, town, or county) (State) Highland, Maryland

DATE REC'D BY LOCAL REG. May 4-1955 REGISTRAR'S SIGNATURE Frank Shipley 24. FUNERAL DIRECTOR De Witt Donaldson Laurel Md ADDRESS

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 10 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04730  
 4730 CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Oregon</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Ellicott City</u>		<u>4 mos</u>		<u>Beaverton</u> <u>74X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor Manor Hospital</u>				STREET ADDRESS (If rural give location) <u>10175 S. W. Old Orchard Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>Elida S. Jilson</u>				<u>May 8 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>May 17, 1863</u>	<u>91</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>			<u>Own Home</u>		<u>Creston, Ill.</u>		<u>U.S.</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Mellen</u>				<u>Annis St. Johns</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Dr. C. L. Newberry 10175 Old Orchard Lane Beaverton, Oregon</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Senility</u>						<u>5 years</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic C.V. D.</u>						<u>8 years</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from <u>Jan. 12, 19 55</u> to <u>May 7</u> , 19 55 that I last saw the deceased alive on <u>May 7</u> , 19 55, and that death occurred at <u>7:45 P.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Dr. J. Taylor</u>		<u>M. D. Taylor Manor Hosp.</u>		<u>May 8, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>5/11/55</u>		<u>Greenwood Cemetery</u>		<u>Rockford, Illinois</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 9, 1955</u>		<u>John B. Loughman</u>		<u>Easton Sons</u>		<u>Catonsville, Md.</u>	

BUREAU V. S.

MAY 19 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04751

4731

## CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Howard	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Rural		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS ELlicott City				STREET ADDRESS (If rural, give location) Old Montgomery Rd., Ellicott City			
3. NAME OF DECEASED (Type or Print) John		(First)		(Middle) Benson		(Last) Lewis	
4. DATE OF DEATH May 7 1955		(Month)		(Day)		(Year)	
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single		8. DATE OF BIRTH 9/20/53	
9. AGE last birthday 1 yr.		If under 1 year Months Days Hours Min.		10. BIRTHPLACE (State or foreign country) Bethesda, Md.		11. CITIZEN OF WHAT COUNTRY?	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		13. KIND OF BUSINESS OR INDUSTRY none		14. MOTHER'S MAIDEN NAME Mary Benson		15. FATHER'S NAME John Fulton Lewis	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		(If yes, give war or dates of service)		17. SOCIAL SECURITY No. none		18. INFORMANT AND ADDRESS William Mahoney, 3306 N. Hilton St., Balto.	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

475X Immediate cause		(a) LARYNGOSPASM, POSSIBLE REFLEX CARDIAC ARREST		INTERVAL BETWEEN ONSET AND DEATH minutes	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) ACUTE TRACHEITIS		hours	
		(c) UPPER RESPIRATORY INFECTION		1 week	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none significant					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, etc.) OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from 4-28, 1955, to 5-7, 1955, that I last saw the deceased

alive on 5-2-55, and that death occurred at 4:20 A.M., from the causes and on the date stated above.

SIGNATURE: Donald E. Fisher (Degree or title) ADDRESS: Ellicott City DATE SIGNED: 5-7-55

23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5/9/55		NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		LOCATION (City, town, or county) Guilford, Md.		(State)	
DATE REC'D BY LOCAL REG. 5-7-55		REGISTRAR'S SIGNATURE Mark Shipley		24. FUNERAL DIRECTOR F.C. Higinbotham		ADDRESS Ellicott City, Md.			

MARGIN RESERVE FOR BINING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is usually important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No. 195

4732

## 1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWNSTREET  
ADDRESS (If rural give location)3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

4. DATE  
OF  
DEATH:

(Month)

(Day)

(Year)

## 5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

## 8. DATE OF BIRTH:

9. AGE last birthday: 15 UNDER 1 YEAR 17 UNDER 24 HRS.  
ys Months Days Hours Min.10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired10b. KIND OF BUSINESS OR  
INDUSTRY

## 11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

480X  
Immediate cause

(a) DUE TO

Antecedent causes (s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b) DUE TO

(c)

Interval Between  
Onset and Death

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.INJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1954 to May 2, 1955, that I last saw the deceased  
alive on May 5, 1955, and that death occurred at 11:30 PM, from the causes and on the date stated above.

SIGNATURE

(Type or Print)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE RECD BY LOCAL

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A. 1910

1910

1910



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4733

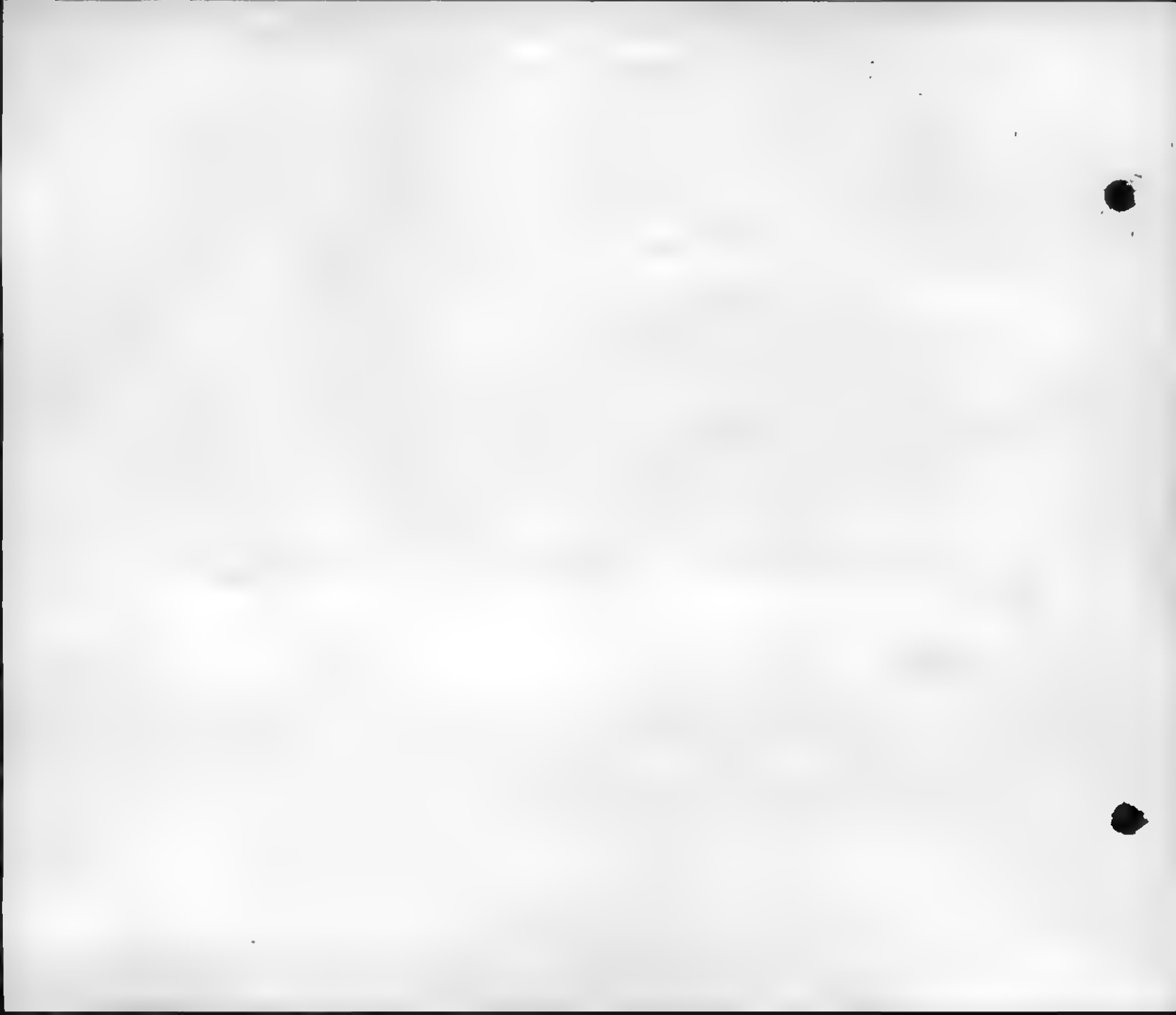
## CERTIFICATE OF DEATH

Reg. Dist. No.

04733

920

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL) <u>Ellicott City</u>	LENGTH OF STAY (in this place) <u>3 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	OR TOWN <u>Baltimore</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor Manor Hospital</u>		STREET ADDRESS (If rural give location) <u>6317 Wallis Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Louis G. Rosenheim Sr.</u>		DEATH: <u>May 16 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept 3, 1937</u>
9. AGE last birthday: <u>81</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Gustav</u>		14. MOTHER'S MAIDEN NAME: <u>Betsy Frank</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Estelle Rosenheim-6317 Wallis Ave.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Failure</u>		<u>15 mon.</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardio vascular disease</u>		<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Senile psychosis</u>		<u>2 years</u>	
19A. DATE OF OPERATION: <u>5/18/55</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
2. I hereby certify that I attended the deceased from <u>May 14, 1955</u> to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>7:30 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Irving J. Taylor</u>		ADDRESS <u>M.D. Taylor Manor Hospital</u> DATE SIGNED <u>May 16, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/18/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-17-55</u>		REGISTRAR'S SIGNATURE <u>Edw. J. Taylor</u>	
FUNERAL DIRECTOR <u>Edw. J. Taylor</u>		ADDRESS <u>Balto., Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04734  
4734 CERTIFICATE OF DEATH

Reg. Dist. No. 19/

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>W. Va.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Ellicott City</u>	<u>3 weeks</u>	OR TOWN <u>Charles Town</u> <u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor Manor Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Charles H. Strider, Sr.</u>		OF DEATH: <u>May 25 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Apr 10, 1892</u>
9. AGE last birthday: <u>63</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>live stock farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>	
11. BIRTHPLACE (State or foreign country): <u>Jefferson Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Nicholas S.S. Strider</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Talbott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>L</u>	
17. INFORMANT & ADDRESS: <u>Charles H. Strider Jr.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4. IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		<u>5 min.</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardio vascular disease yrs ?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Depression</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>3 mos</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
2. I hereby certify that I attended the deceased from <u>May 5, 1955</u> to <u>May 25, 1955</u> that I last saw the deceased alive on <u>May 25, 1955</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Dr. J. Taylor</u>		ADDRESS <u>M. D. Taylor Manor Hosp. May 25, 1955</u> (State) <u>W. Va.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 28, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Edge Hill</u>		LOCATION (City, town, or county) <u>Charles Town, W. Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-27-55</u>		REGISTRAR'S SIGNATURE <u>John B. Loughran</u>	
24. FUNERAL DIRECTOR <u>W. H. Loughran</u>		ADDRESS <u>Ellicott City Md.</u>	

MARGIN RESERVED FOR BINDING

A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNIVERSITY OF CHICAGO



MARYLAND

STATE DEPARTMENT OF HEALTH

4735

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH- COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Howard</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Fulton</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Fulton</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <b>ARTHUR</b> (Middle) <b>E.</b> (Last) <b>WESSEL</b>		4. DATE OF DEATH (Month) <b>MAY</b> (Day) <b>23</b> (Year) <b>1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>12-18-1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	9. AGE last birthday <b>73</b> yrs. If under 1 year: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Fulton, Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Herman F. Wessel</b>		14. MOTHER'S MAIDEN NAME <b>Catherine D. Hines</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Albert Wessel, Fulton, Md</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <b>420.1 Coronary Thrombosis</b>			<b>1 wk.</b>
(b) Antecedent cause(s) <b>Diabetes Mellitus</b>			<b>4 yrs.</b>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>Hypertensive C.-V. Disease</b>			<b>10 yrs.</b>
(c) <b>Cerebral Hemorrhage</b>			<b>1 yr.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>2/12</b> , 19 <b>52</b> , to <b>5/23</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>5/23</b> , 19 <b>55</b> , and that death occurred at <b>m</b> from the causes and on the date stated above.			
SIGNATURE <b>J. M. Warren M.D.</b>		ADDRESS <b>Laurel Md</b> DATE SIGNED <b>5/23/55</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE <b>5-26-55</b> NAME OF CEMETERY OR CREMATORY <b>St. Pauls Lutheran</b> LOCATION (City, town, or county) <b>Fulton, Md</b> (State)	
DATE REC'D BY LOCAL REG. <b>5-27-55</b>		REGISTRAR'S SIGNATURE <b>Marie G. Whitaker</b> 24. FUNERAL DIRECTOR <b>F.C. Higginbotham, Ellicott City, Md</b> ADDRESS	

BUREAU V. S.

JUN 3 1955

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. ....

Reg. Dist.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Howard</u>		MARYLAND	STATE <u>Maryland</u> COUNTY <u>Howard</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR		
TOWN <u>Ellicott City</u>			TOWN <u>Ellicott City</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>81 Columbia Road</u>			STREET ADDRESS (If rural, give location) <u>81 Columbia Road</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
<u>Margaret Beavers Campbell White</u>			<u>5-31-55</u> 19		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>9-28-1912</u>	<u>42</u>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Unknown</u>			14. MOTHER'S MAIDEN NAME: <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
<u>No</u>		<u>212-20-7084</u>	<u>Elmer White, Ellicott City, Md</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<u>Instant</u>
<u>420.1</u> Immediate cause (a) <u>Coronary thrombosis</u> DUE TO				
Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE <u>George E. Beery</u> DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-1-1955</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6-4-55</u>	NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>	LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>
DATE REC'D BY LOCAL REG. <u>6-3-55</u>		REGISTRAR'S SIGNATURE <u>John B. Laughan</u>		24. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md</u> ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 4

JUN 13 1955

RECEIVED